On the Brain Disease Model of Mental Disorders

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We read with interest Steven Bruce’s (2009) summary of the NIMH Professional Coalition for Research Progress 2008 report in the February issue of the Behavior Therapist. Our attention was drawn to the first of NIMH director Dr. Thomas Insel’s position statements: “mental disorders are brain disorders” (p. 41). This position is closely linked to the first major objective in NIMH’s strategic plan, namely, to “promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders (i.e., genes to circuits to behavior)” (p. 41). To be sure, significant advances have been made in understanding mind-brain relationships and the role of biological vulnerabilities in the development of mental disorders (e.g., Caspi et al., 2003). However, we are concerned that the enthusiastic promotion of the brain disease model by NIMH and other prominent sources (e.g., National Alliance on Mental Illness, the pharmaceutical industry) has far outstripped the available scientific data and may actually be increasing the stigma associated with mental disorders.

Dr. Insel’s statement that “mental disorders are brain disorders” suggests that problems like anxiety and mood disorders are caused by identifiable brain abnormalities. Insel elaborated on this position at the 2008 annual meeting of the American Psychiatric Association by explaining that mental disorders are not caused by brain lesions as with neurological disorders, but rather from abnormal development of brain circuitry (Moran, 2008). We note that there is no diagnostically useful test for identifying abnormal brain circuitry for common mental disorders. Similarly, Dr. Insel recently con-
cluded that “genomic studies will likely not yield a diagnostic test, identify a cause, or develop specific gene therapies for mental disorders” (Bruce, 2009, p. 41). In fact, decades of research have failed to identify any biological marker with sufficient positive and negative predictive power to reliably inform psychiatric diagnosis. Thus, NIMH appears to endorse the incongruous position that (a) mental disorders are the product of a disordered brain, and (b) there is no diagnostically useful laboratory test capable of demonstrating a brain abnormality, nor will such a test likely ever exist.

The NIMH position typifies the dominant cultural narrative in the United States—that mental disorders are viewed as brain diseases, chemical imbalances, and diseases like any other (Frase, Lysaker, & Robinson, 2007). Psychologist Stanton Peele captured the atmosphere of excitement surrounding biological models when he noted that a “breakthrough mentality now exists among many biologists, neurologists, and psychologists who feel that we are on the verge of discoveries in the fields of biology, genetics, and the neurosciences that will remove some of our most persistent human problems” (p. 808). Peele’s observation was published in 1981, and enthusiasm for the biological model has only increased in the ensuing 28 years. In spite of this, the intervening decades have not witnessed the expected advances in biological technology for diagnosing, preventing, treating, or eliminating common problems like mood and anxiety disorders. To illustrate, newer-generation antipsychotics, despite having fewer extra-pyramidal side effects, are no more effective than first-generation agents (e.g., Jones et al., 2006). Similarly, newer-generation antidepressants—now the most prescribed medications of any kind (National Institute for Health Care Management, 2002)—are no more effective than older tricyclic antidepressants in the treatment of depression (Geddes, Freeman, Mason, Eccles, & Boynton, 2000) or panic disorder (Otto, Tuby, Gould, McLean, & Pollack, 2001).

One reason that mental disorders are described as brain diseases by scientific authorities, despite failing to meet the basic definition of a disease—an abnormality in bodily structure or function—is the reductionist philosophy that abnormal psychological phenomena are the product of a disordered brain. To illustrate, the Surgeon General’s Report on Mental Health (U.S. Department of Health and Human Services [USDHHS], 1999) explains that it is a “core tenet of modern science that behavior and our subjective mental lives reflect the overall workings of the brain. Thus, symptoms related to behavior or our mental lives clearly reflect variations or abnormalities in brain function” (p. 39). According to this philosophy, any “abnormal” cognition, emotion, or behavior is, by definition, the product of a disordered brain. Thus, the hypochondriasis patient’s belief that unexplained somatic symptoms indicate the presence of terminal cancer, or the socially phobic individual’s avoidance of public speaking, is assumed to be the product of biological abnormalities in the brain without regard to whether any such abnormalities are known to science.

There is little question that all psychological phenomena have biological underpinnings. “Reductionism” comes in different forms (Lilienfeld, 2007), and few would take issue with the constitutive reductionist notion that all mental events are ultimately rooted in the brain, or that it is an important scientific endeavor to uncover the biological correlates of psychological experience. However, the notion that “mental disorders are brain disorders” represents an eliminative reductionistic perspective in which higher-level psychological processes such as thoughts, emotions, and behaviors are entirely explained by their putative biological causes. From this point of view, an association between biological variables and mental disorder symptoms may be interpreted as demonstrating the disease process that caused the disorder. This perspective leaves little room for the possibilities that apparent biological abnormalities might be the result of a mental disorder, a consequence of chronic psychotropic medication use (Leo & Cohen, 2003), confounded by affect-induced physiological changes during the biological test (Whiteside, Port, Deacon, & Abramowitz, 2006), or reflect a vulnerability for developing a mental disorder without directly causing it (Caspí et al., 2003).

The eliminative reductionistic philosophy may also encourage the misinterpretation of biological processes associated with nondisordered human experience as pathological. To illustrate, consider a recent success story in NIMH’s efforts to translate findings from basic laboratory science into clinical practice. Evidence from animal research suggests that fear extinction is mediated by N-methyl-D-aspartate (NMDA) receptor activity in the basolateral amygdala (Davis, 2002). Using this knowledge, researchers have documented that D-cycloserine (DCS), a partial agonist at the NMDA receptor, facilitates fear extinction in exposure therapy for many different anxiety disorders (Norberg, Krystal, & Tolin, 2008). Anderson and Insel (2006) interpreted these findings as useful in potentially identifying the pathophysiology (i.e., disordered function caused by a disease) of anxiety disorders. Their position is consistent with the eliminative reductionistic philosophy in which the biological processes associated with a mental disorder are assumed to be abnormal. However, the DCS literature suggests that fear extinction is facilitated for individuals with anxiety disorders through activation of the same neural circuitry that underlies fear extinction in the normal brain. In fact, this successful translational research paradigm is predicated on the assumption that the same nondisordered physiological processes underlie fear extinction in the brains of normal and clinically anxious individuals.

In addition to the philosophy of eliminative reductionism, mental disorders are often attributed to a brain disease in an effort to reduce stigma. This stance is exemplified by NAMI’s (2009) position that “mental illnesses are biologically based brain disorders. They cannot be overcome through ‘will power’ and are not related to a person’s ‘character’ or intelligence.” Such messages appear based on the assumption
that most individuals believe mental disorders to be caused by a character flaw, and that attributing mental disorders entirely to biology will reduce stigma by correcting this misconception. This notion is aptly illustrated by the following passage from the Surgeon General’s Report on Mental Health (USDHHS, 1999): “When people understand that mental disorders are not the result of moral failings or limited willpower, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate” (p. 9).

The belief that mental disorders are the product of personal failings is undoubtedly held by some psychiatric patients and members of the general public. However, empirical evidence indicates that this view is actually uncommon. Community surveys have reliably found that lack of willpower and immorality are the least endorsed causes of problems such as depression and schizophrenia ( Dietrich et al., 2004; Jorm et al., 1997; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). In contrast, biological causes associated with genes and chemical imbalances are endorsed by the vast majority of community members ( Schnittker, 2006). As such, disease-based antistigma messages (e.g., “depression is a flaw in chemistry, not character”) are focusing on the wrong target.

By ascribing psychopathology to brain defects rather than personality flaws, brain disease models appear to reduce the extent to which individuals with mental disorders are blamed for their conditions ( Goldstein & Rosselli, 2003; Phelan, Cruz-Rojas, & Reiff, 2002). Unfortunately, this benefit comes at a price. Because biological models foster the perception that individuals with mental disorders lack control over their behavior, they may be viewed by others as unpredictable, dangerous, unable to care for themselves, requiring harsher treatment, and fundamentally different from those without mental disorders ( Angermeyer & Matschinger, 2005; Hill & Bale, 1981). One experiment found that participants delivered more intense electrical shocks to confederates described as having a biologically based mental health problem than those whose symptoms were ascribed to psychosocial causes ( Mehta & Farina, 1997). These authors suggest that viewing people with mental disorders as diseased produces a patronizing attitude in which they must be treated firmly and, owing to their biochemical aberrations, are perceived as “almost another species.”

Antistigma campaigns often aim to increase mental health literacy by instructing people that mental disorders are brain diseases and illnesses like any other. For example, Watson et al. (2004) used items such as “Mental illness is like other diseases because a person who has it has symptoms that a doctor can diagnose” to teach children that mental disorders are “illnesses of the brain.” As noted in the 1999 Surgeon General Report, widespread efforts to educate the public about the brain disease model over the past 40 years appear to have been successful. Ironically, the report also noted that “stigma was expected to abate with increased knowledge (emphasis added) of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved” (p. 8). This observation is consistent with a large body of research indicating that biological explanations of mental disorders are reliably associated with increased fear and prejudice (see Read, 2007, for a review). As such, the widespread dissemination of the brain disease model by NIMH and others may be actively worsening the very stigma they seek to reduce.

In addition to exacerbating prejudicial attitudes among the general public, biological models may powerfully affect how individuals with mental disorders view themselves. Patients sometimes attribute their symptoms to personal failings, and well intentioned treatment providers may convey a brain disease explanation in an attempt to change such perceptions. Indeed, depressed patients frequently receive a biological causal explanation from physicians, and adoption of this explanation alleviates concerns that a personal weakness caused the problem ( Schreiber & Hartrick, 2002). However, as with public stigma, there appears to be a cost associated with encouraging patients to view their symptoms as the product of a diseased brain.

Our lab recently conducted a study in which undergraduate participants were asked to imagine seeking help from a doctor who diagnosed them with major depressive disorder and provided either a brain disease or biopsychosocial explanation for their symptoms (Deacon & Baird, 2009). The brain disease explanation led to substantially less self-blame than the biopsychosocial explanation, but was associated with a worse expected prognosis, decreased self-efficacy in managing depression, and the perception that psychosocial interventions would be ineffective. This study is limited by the use of a nonclinical sample and thought experiment methodology. Nevertheless, to the extent that these findings generalize to treatment-seeking patients with mental disorders, it is possible that the brain disease model fosters beliefs about oneself, one’s disorder, and treatment that could interfere with clinical improvement. Expectancies are an important predictor of treatment outcome (Kirsch, 1999), and individuals who accept a reductionistic biological model of their symptoms may expect psychological problems to be outside of their control (Fisher & Farina, 1979) and largely unresponsive to nonbiological treatments (Deacon & Baird, 2009; Schreiber & Hartrick, 2002).

We believe it is time for an honest assessment of the fruits of the eliminative bioreductionistic approach. To date, the hope that biological research might revolutionize the diagnosis and treatment of mental disorders, and even eliminate the distinction between neurological and psychiatric disorders altogether (Insel, 2007), has not materialized. Moreover, public stigma appears to have increased in the context of widespread dissemination and adoption of biological models. Lastly, acceptance of the brain disease explanation by patients may create self-efficacy beliefs and outcome expectancies that are in opposition to those cognitive-behavioral therapists strive to instill.

The current faith of bioreductionistic proponents that we are on the verge of transformative breakthroughs appears eerily similar to the climate described by Peele in 1981. The fact that biological research has not led to the expected revolution in the understanding and treatment of mental disorders does not mean that such a revolution will never occur, or is not occurring at this very moment. Without question, scientific efforts to uncover the biological underpinnings of mental disorders are critically important, and any revolutionary discovery (biological or otherwise) that improves the lives of individuals with mental disorders should be celebrated. However, it is most consistent with the scientific tenet of open-minded skepticism to calibrate one’s adherence to a theory in accordance with the strength of evidence in support of its validity and usefulness. In the case of the “mental disorders are brain disorders” model, the failure to do so has potentially serious implications for the well-being of our patients.

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Recommendations for Recruiting and Managing Undergraduate Research Assistants

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Undergraduate students are often integral to the execution of behavioral research. Their assistance can range from data entry and library research to conducting sessions and data analysis. Through their involvement, undergraduate students can acquire valuable skills, learn firsthand about the research process, make important contacts with faculty members and graduate students, and earn letters of recommendation for employment and graduate school.

Despite the ubiquity of undergraduate research assistants in behavioral psychology, it is often challenging to recruit them and manage their behavior during the course of a research study. A number of authors have explored various aspects of the undergraduate research experience from which a number of recommendations can be extracted. Gibson, Kahn, and Mothi (1996) evaluated two different models of training experiences for undergraduate research assistants. The authors recommended that faculty members who conduct closely related studies allow students to participate in a greater number of research projects, based on the premise that this would optimize the number of resources and ideas for each study. The converse was recommended for labs in which studies are not closely related. DiBartolo and Shutts (2000) recommended that faculty supervisors provide research assistants with a lab manual, and use a written contract to define the supervisor-assistant relationship. Starke (1985) recommended scheduling weekly meetings with undergraduate research assistants in which study-specific duties can be discussed along with more general academic topics (e.g., research methodology). Gant, Dillon, and Malott (1980) described a behavioral system for supervising undergraduate research. Some of the authors’ recommendations included written descriptions of tasks, clearly defined criteria for task completion, and deadlines for the completion of mandatory tasks. In addition, Gant et al. recommended the delivery of rewards for completing tasks and aversive consequences for failure to complete tasks, keeping performance records of the number of complete and incomplete tasks, and weekly meetings between undergraduate research assistants and a graduate-student supervisor.

Collectively, the aforementioned articles provide helpful recommendations regarding working with undergraduate research assistants. The purpose of the present article is to describe a more comprehensive system that addresses issues from recruitment of research assistants to their supervision during a study’s execution. Our recommendations are intended for junior faculty and graduate students (hereafter referred to as superintendants) because, although overseeing research assistants is a common and important duty, these repertoires are rarely explicitly taught in graduate school.

The Recruitment Process

Recruiting From Classrooms

Recruitment might be the most critical step in the process of acquiring and maintaining a team of undergraduate research assistants. The first point of consideration is the timing of your recruitment efforts. Recruit students 2 to 3 weeks before registration opens as they will likely know their schedules for the following semester at that time. A common method of recruitment is to contact students in upper-level courses related to the major (Starke, 1985). While actively recruiting students in the classroom, use a script to ensure that important details are presented and ensure consistency between different recruiters. We also recommend developing and requiring the completion of an application by students interested in becoming research assistants. The application may include prior experience relevant to research, grade point average (GPA), academic status, and professional goals and interests. It is important to make students aware of the applications, where they can obtain them, where they should be returned, and the deadline for submitting them. How carefully a student completes the application and whether it is submitted on time can be useful indicators of existing professional behavior. It may be useful to bring a sign-up sheet when recruiting in a classroom should e-mailing the application to interested students be a viable option. If a graduate student is recruiting from courses taught by other faculty members, the process for obtaining approval to do so should be carried out in a respectful manner. In addition, keep any in-class recruitment presentation as brief as possible to avoid the loss of valuable instructional time.

In addition to recruiting research assistants directly from courses, supervisors may also contact former high-performing students whom they have taught, recruit from meetings of Psi Chi and psychology clubs, and post recruitment flyers throughout the building. Regardless of the method of initial contact, however, it is important to thoroughly screen applicants carefully and eventually invite the most promising of them to a face-to-face interview.

Interviews

Interviewing potential research assistants can be challenging. We believe it is important to address the following topics in an interview: (a) undergraduate major status, (b) plans for attending graduate school and primary area of interest within psychology, (c) previous experience on research or practicum teams, (d) GPA, (e) questions with respect to experience with the population of interest in the study, (f) transportation, (g) reasons for wanting to participate on a particular research team, and (h) student availability during the semester in question. We recommend that students selected for interviews have a strong passing grade in a prerequisite research methods course and exhibit appropriate professional behavior during the interview (e.g., on-time arrival, noncolloquial language, appropriate attire). Junior graduate students should conduct their first few interviews with a more experienced peer or faculty member. To increase the likelihood of selecting high-quality research assistants, interview two to three times the number of potential research assistants needed for the project.

Finally, we recommend developing a syllabus for the research experience before conducting interviews. The syllabus should describe the research assistant’s responsibilities, performance expectations, procedures for emergency absences and lateness, and a
grading system in which specific point values are awarded for appropriate performance (e.g., participation in team meetings, accurate data collection) and withdrawn for inappropriate performance (e.g., missed sessions, unprofessional attire at the research site). Show the interviewees the syllabus so they can be aware that the experience is structured with clearly stated expectations of performance. This may further impress upon them the importance of their role within the research infrastructure.

Enrollment

Students often assist with research for course credit, which requires several considerations. Make certain that students know how to register for research or elective credit, especially if special permissions are required. The supervisor should make certain that students are registered for research credit at the beginning of the semester to ensure they are covered under the university's umbrella liability policy during the research project. We recommend allowing students to serve as volunteer research assistants only when they have prior experience working in the lab and when a volunteer can meet the conditions for university liability coverage. Our hesitation regarding volunteer research assistants is a result of a history of excellent volunteers leaving mid-way through the project to pursue more attractive experiences. One can easily avoid this quite intrusive problem by having research assistants register for course credit. Finally, it is necessary to consider institutional review board (IRB) and site requirements as part of the enrollment process. If research assistants have contact with human participants, investigate the IRB's requirements regarding training, screening, and other related issues. If data collection is conducted outside of the lab, check whether the research site has its own requirements for research assistants (e.g., background checks). This step is important to ensure that the research assistant is eligible and able to fully participate on the research project. Ideally, all paperwork related to these issues is completed before the semester begins.

Research Team Meetings

Regularly scheduled research team meetings facilitate open and clear communication between team members and can optimize the learning environment for all parties involved (Gant et al., 1980). The agenda for the first team meeting is critically important because it sets the tone for the working environment for the remainder of the semester. The first portion of the meeting should be dedicated to discussing structural issues such as the syllabus, grading policy, general duties, etc. The second portion of the initial team meeting should be dedicated to discussing the importance of the students' role in the research process and their ethical responsibilities as a research assistant (e.g., confidentiality, data integrity) under the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) and the university's IRB protocol. You might also find it useful to describe potential consequences to the research team (including the principal investigator) for scientific misconduct and violations to the IRB protocol. We believe that such a "big picture" overview of the research team and the research assistant's role within it underscores the importance of teamwork and compliance with the research protocol.

The Semester's Activities

Primary Duties

Early in the semester, research assistants should be introduced to the relevant research question(s), as well as the main concepts addressed in the line of research. This will provide a framework for discussions of assigned articles on the topic and subsequent training of primary research duties. We recommend that research assistant duties be prioritized and that training intensity and proficiency standards be established accordingly (see section on Obtaining Optimal Performance). Research duties may include, but are not limited to: (a) data collection; (b) implementation of the independent variable; (c) calculation of interobserver agreement and procedural fidelity; (d) data entry and analysis; (e) how to interact appropriately with participants, families, and other professionals; (f) developing data sheets; (g) creating research materials; and (h) problem solving research-related difficulties.

Enrichment Activities

After the primary research-related duties are addressed, we have found it beneficial to include several enrichment activities during the semester. These activities, although inherently valuable, are particularly helpful in maintaining a meaningful educational experience throughout the semester, especially during lulls in research activity. Potential enrichment activities may include: curriculum vitae development, graduate school preparation (e.g., interview

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skills), professional skill development (e.g., delivering presentations, writing a personal statement), and the research process in general (e.g., conducting literature searches). The types of activities and the frequency with which they are scheduled may depend on the topic of the research study, the number of hours research assistants have committed to the project during enrollment, the number of semesters research assistants have worked on the team, how often the research team meets, and the number of hours research assistants spend performing primary research duties.

Obtaining Optimal Performance

It is important to establish the relevant contingencies to obtain optimal performances from research assistants. The supervisor should provide a task analysis for each of the duties associated with participation on the research team so that research assistants can perform them competently. In addition to providing a written task analysis, we recommend that research assistants be trained on each primary duty, with modeling and rehearsal when appropriate, and that they meet a predetermined proficiency standard during training for all skill areas germane to the project (e.g., data collection). Additionally, the consequences for not performing a duty as expected (e.g., point loss, dismissal from the research team) as well as consequences for exemplary performance (e.g., letter of recommendation, promotion within the team) should be outlined for the research assistants.

In our experience, providing research assistants with regular feedback on their performance helps them maintain and improve their performance across research-related activities (Gant et al., 1980). We also recommend providing feedback in a timely manner (e.g., about 1 week) for homework assignments and research-related activities, and conducting formal performance evaluations at the middle and end of the semester. Finally, the supervisor should model professional behavior. Professional behavior includes, but is not limited to, punctuality, deportment (e.g., dress, appearance), and collegial behavior during meetings.

Social Validity

We e-mailed a link to a 5-item Internet survey (with Likert-scale response options) to everyone who had participated as a graduate-student supervisor within the system described in this article. Eleven of the 13 (84.6%) individuals responded to the survey. Ninety percent of respondents indicated that they found this system valuable with respect to recruiting and supervising a team of undergraduate research assistants. Furthermore, the results indicate that these individuals had a positive experience working within this system and would recommend it to other supervisors.

We also e-mailed a link to a 10-item Internet survey (with Likert-scale response options) to the 40 most recent undergraduate research assistants who had been recipients of the system. Sixteen (40%) of the assistants responded to the survey. Ninety-four percent of respondents indicated that the research experience increased their knowledge and expertise with respect to research-related activities such as data collection, calculating interobserver agreement, and implementation of independent variables. Ninety-four percent of respondents reported that the experience prepared them to apply to a graduate program or gain employment in a related area. Eighty-one percent of respondents indicated that regularly scheduled team meetings enhanced their experiences as a research assistant with respect to assisting with planning the next course of action on the study, discussing concepts relevant to the study, and interacting effectively with their peers and supervisor. Eighty-eight percent of respondents reported that the feedback they received from their supervisors was beneficial to their performance. Finally, 94% of respondents indicated that they would recommend this specific research assistant experience to other undergraduate students.

The survey results should be viewed in the context of at least limitations. First, demand characteristics may have influenced responding as all respondents were former undergraduate or graduate students of the third author. However, this limitation is likely mitigated by the fact that all surveys were completed anonymously. Second, the survey response rate for former undergraduate research assistants was low. Thus, data from that survey may not be representative of the 60% individuals who did not respond. Limitations notwithstanding, the social validity surveys do indicate a generally high level of consumer satisfaction with the system from both graduate-student supervisors and undergraduate research assistants.

Conclusion

Recruiting and maintaining a strong team of undergraduate research assistants is vital to the execution of research. We hope the system described in this article, which has proven useful to our former undergraduate students and their graduate-student supervisors, will provide junior faculty members and graduate students who find themselves in the position of executing these tasks a clear and helpful guide to successfully achieving this goal. However, the system described in this article was developed in the context of a specific psychology department, research lab, and group of researchers. As such, all of the present recommendations may not be appropriate for other research circumstances. For example, one would reasonably expect differences in recruiting and managing research assistants between (a) liberal arts colleges and major research universities, (b) large and small research labs, (c) basic and applied research labs, and (d) departments with and without academically strong undergraduate students. Thus, potential adopters of the system presented herein might focus less on its specific tactics and more on its general strategy of explicitly designing the undergraduate research assistant experience across the areas of recruitment, performance management, and mentorship.

References


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Logging on for Nodding Off: Empowering Individuals to Improve Their Sleep

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Regular, chronic insomnia is a common and disabling health care problem, affecting 9% to 9.5% of the population (Morin, LeBlanc, Daley, Gregoire, & Merette, 2006). Individuals with chronic insomnia are at increased risk for stroke, diabetes, alcohol abuse, depressive episodes, neuropsychological deficits, and automobile accidents (Balter & Uhlenhuth, 1992; Crum, Storr, Chan, & Ford, 2004; Elwood, Hack, Pickering, Hughes & Gallagher, 2006; Ford & Kamerow, 1989; Kawakami, Takatsu & Shimizu, 2004) and they are more likely to be absent from work and to be less productive at work (Godet-Cayré et al., 2006; Melamed & Oksenberg, 2002). The two main treatments for insomnia include pharmacotherapy and psychotherapy; however, consumers often express a preference for psychological therapies (Vincent & Lionberg, 2001).

Cognitive-behavioral therapy for insomnia (CBT-I) has been shown to be highly effective, producing reliable and durable improvements in sleep in about 70% to 80% of patients with primary insomnia and approximately 60% of patients with comorbid insomnia (Lichstein, Wilson, & Johnson, 2000; for a review of effect sizes see Morin et al., 2006). Despite the widespread occurrence of chronic insomnia, research suggests that a significant proportion of individuals with sleep problems do not seek treatment (Morin et al., 1993; often due to lack of awareness and accessibility of treatment options. Such factors have spurred research interest in the efficacy of low-intensity and self-administered treatments for insomnia. A recent review of this literature suggests that self-administered forms of CBT-I (e.g., manuals, audiotapes, television, video, Internet, or telephone consultation) can be effective in reducing symptoms of insomnia, although they may be inferior to in-person treatment (Currie, 2008).

One of the most promising avenues for delivering self-administered CBT-I is through the use of an Internet-based platform. Online programs have a number of advantages, including ease of access, flexibility of timing, privacy, and convenience (Griffiths & Christensen, 2006). Unlike paper-based media, Internet programs can incorporate a variety of audiovisual materials that encourage user engagement and interaction. They often have no cost associated with them and content can be updated with ease and tailored to geographic and linguistic preferences. Online treatments may also provide a valuable alternative in cases where traditional services are unavailable (e.g., in rural or remote regions) or where waiting lists for in-person CBT-I are prohibitively long. Further, practitioners can utilize online treatments as an adjunct to in-person treatment, delivering CBT with purity and ease (Christensen, 2007). Indeed, having more tools at the practitioner’s disposal (e.g., mp3 files for relaxation) saves time and allows for more individualized attention.

**Online Treatment of Insomnia**

Prior to the development of our program, only one study had been published examining computerized cognitive behavioral therapy for insomnia (cCBT-I; Strom, Pettersson, & Andersson, 2004). The online program offered through our clinic expands upon previous work by incorporating a wider range of multimedia resources (including audiovisual teaching files and downloadable mp3 files for relaxation) and utilizing a more heterogeneous sample of participants, many of whom have been nonresponsive to medication. All potential participants are first screened by telephone to confirm the presence of insomnia using the Insomnia Interview Schedule (Morin, 1993), and to identify factors that might indicate a lack of appropriateness for cCBT (e.g., suicidality, mania, psychosis, head injury, excessive alcohol use). Interested and eligible participants receive a password by email, which allows them to access the website to complete the consent form, pretreatment questionnaire package, and sleep diaries. Once participants have logged in using a secure username and password, they are invited to view a menu with links to video clips, questionnaires, audio files, and written material, arranged into five weekly modules. Participants work through the modules on their own, but are asked to log on at the same time every day and to complete sleep diaries and adherence questionnaires. They are invited by the online coordinator midway through the program to comment on their progress and ease of use of the program. Also, participants are informed that they may contact the study coordinator by email or telephone with questions or concerns at any time. The content of the modules is described in more detail in Table 1 and is based on Morin’s (1993) cognitive behavioral model of insomnia.

**Effectiveness of cCBT-I**

Online treatment appears to be a highly acceptable treatment option. At our outpatient sleep clinic, only 8% of individuals decline participation due to lack of interest or concerns about computer-based administration (see Figure 1). When compared to a waiting-list control group, participants in a 5-week trial of cCBT reported significant improvements in insomnia severity (p < .0001), general fatigue (p < .01), and sleep quality (p < .0001). Online treatment also resulted in a reduction in erroneous beliefs about sleep (p < .0001) and presleep mental activity (p < .002). Effect sizes ranged from small (time spent awake during the night) to large (insomnia severity) (Vincent & Lewycky, in press). In terms of clinical significance, 81% of treated participants rated themselves as improved as compared to 30% of those in the control group (see Figure 2). Satisfaction among those who completed cCBT (M = 25.11, SD = 4.66) is somewhat less than those receiving in-person group treatment at the same site with an identical protocol (M = 26.72, SD = 3.82); t(134) = 2.16, p = .03. We have found that those enrolled in our cCBT trial were more likely to drop out prior to treatment completion compared to those enrolled in our in-person program (31.6% vs 15.2%) Chi^2 (2, N = 255) = 8.52, p = .01. Those who dropped out of cCBT were more likely to have a less severe presentation of insomnia (Hebert, Vincent, Lewycky, & Hart-Swain, 2009), and so it is possible that attrition is not necessarily reflective of treatment failure of cCBT, but instead may indicate that many individuals need a smaller “dose” of treatment for this problem.
Implications for Practitioners

Having established that cCBT is viewed favorably and is associated with significant and positive outcomes, what are the implications for the practitioner who provides CBT for sleep disorders? We surveyed a small number of completers (n = 15) of cCBT as to whether they would see a psychologist in the future for a sleep problem. Of those surveyed, 73.3% (11 out of 15) indicated that they would do so. Moreover, individuals who completed cCBT anticipated that their online experience would make their subsequent in-person CBT experience even more rewarding as they would be aware of what areas of treatment to target. Lastly, 66% (n = 10 out of 15) of participants noted that they learned something new about the role of psychology in promoting better sleep after participation in cCBT.

It is clear that the psychological aspect of cCBT is highly valued by participants. Our outpatient program is set up as a stepped-care model, which allows individuals to select the level of intervention appropriate for their needs. Initially, a low-intensity intervention (cCBT) is offered, followed by an opportunity for a single-session consultation, next by an opportunity for group treatment, culminating in an opportunity for individual in-person treatment. Stepped care is not only prudent fiscally, but providing patients with treatments of their choice has been associated with better adherence and outcomes (Raue, Schulberg, Heo, Klimstra, & Bruce, 2009). Data from our center show that significantly more completers of cCBT, relative to waiting-list controls, request a single-session consultation (60% vs. 0%). In contrast, relative to those on a waiting list, significantly fewer completers of cCBT enroll in a 6-week group treatment conducted at our site when offered such an opportunity (20% vs. 71%). Completers of cCBT may request less intensive in-person services due to feelings of demoralization regarding lack of progress with cCBT, the expectation that there is nothing left for a psychologist to offer beyond the techniques taught in cCBT, or because individuals were much less distressed after completion of cCBT. We favor the latter explanation, based on feedback obtained through a focus group and through responses to a treatment survey.

What Moderates Outcome in cCBT?

Predictors of outcome for online programs targeting anxiety disorders have been age, education, pretreatment severity (with less severe presentations having better outcomes), treatment credibility, pretreatment motivation, and supportive contact during the program (see Newman, Erickson, Przeworski, & Dzus, 2003, for a review). In the online treatment of insomnia, we speculate that obsessiveness, perfectionism, attention span, reading ability, and preference for self-reliance may moderate outcome. For example, our group has found that overly obsessive individuals are often distraught by having to commit to a response option for questionnaire items and to complete a regular sleep diary. Extra therapist encouragement to avoid spending too much time thinking about responses may be necessary for these individuals to proceed. Similarly, individuals with a high level of perfectionism may have difficulty with setting realistic goals for cCBT in the absence of a therapist. This unrealistic goal setting occurs even when substantial normative information regarding sleep across the lifespan is provided to aid in the development of realistic goals (thanks to the superb work of Kenneth Lichstein and colleagues, 2004). We have also encountered a few individuals who felt unable to participate in cCBT due to problems with sustained attention or because they had a

<table>
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<th>Table 1. Description of Online CBT-I Program</th>
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<td>1. Psycho-education</td>
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<td>2. Sleep hygiene</td>
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<td>3. Relaxation</td>
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<td>4. Sleep restriction</td>
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<td>5. Cognitive therapy</td>
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reading disorder. Finally, we anticipate that one of the more important moderators of treatment is a self-reliant personality style. Individuals who are sensitive to being intruded upon may be particularly good candidates for self-help. Related to this concept, we have found that those with a more internal sleep locus of control tend to be more satisfied with cCBT. One intriguing finding of this study was that individuals completing our Internet-based program experienced a greater shift in their perception that their insomnia is contingent upon their behavior relative to those in our in-person sessions. This is consistent with theories suggesting that self-administered treatment may help to foster self-efficacy and intrinsic motivation (e.g., Richards, 2004).

Lessons Learned

Some issues flagged by cCBT participants have been a desire to have a discussion forum as part of the website, to have a text box beside questionnaires to allow for the inclusion of personal comments, to have the option of being contacted by email or phone on a periodic basis, and to expand upon the cognitive therapy module. Participants of cCBT also indicated that it was helpful to have a brief but effective intervention in the first module (refraining from watching the clock) to inspire hope and commitment. Investigators in this area should be aware that those who use cCBT are also those who tend to surf for health-related information on the World Wide Web. Thus, surfing for treatments for insomnia may contaminate treatment trials in the same way as participating in therapy outside of a research protocol contaminates therapy trials.

Future Directions

As access to CBT-I is less than optimal, owing to a host of factors, novel methods of service delivery must be developed and evaluated. Future research in our clinic will compare results from our online program to results obtained upon delivery of the same program using teleconferencing technology (telehealth) and will strive to identify for whom cCBT-I is effective. A secondary research goal is to examine the impact of fatigue on readiness for change, treatment adherence, dropout, and health behavior. Preliminary results in this area suggest that fatigue, while often neglected in the research literature, may be an important factor to consider in treatment planning.

References


Letter to the Editor

The Second Edition of Aaron Beck’s First Book

Brad Alford, University of Scranton

It might be of interest to readers to know of the publication of a second edition of the first book on cognitive therapy, *Depression: Causes and Treatment* (Beck, 1972). The research program described in the first edition led not only to cognitive therapy and therapy of depression, but it also outlined the cognitive theory of psychopathology in general. For example, the negative cognitive triad in depression was identified, along with the theory of bipolar disorder and others, including anxiety, phobia, somatization, paranoia, obsessive-compulsive disorders, and psychosis.

Because of the prescient nature of the first edition, much was retained in the new edition. The theoretical perspective of the first edition has generated many lines of elaborative research. For example, the original theory on the development and precipitation of depression has generated priming and longitudinal design studies supportive of the cognitive formulation.

In addition to the original research and theory of cognitive therapy, readers may be interested in an overview of new developments in our contemporary understanding of depression. Changes and improvements have occurred in the somatic treatments. New antidepressants are available along with augmentation and switching protocols, as well as other improvements to deal with treatment resistance. Placebo-controlled studies of drug combinations have been conducted. The data on ECT are more definitive. Transcranial magnetic stimulation and pharmacogenomics are advancing towards clinical implementation.

Pharmacological agents like the SSRIs have shown better side-effect profile, greater safety in case of overdose, and improved tolerability and patient compliance. The depression-focused psychotherapies have evolved. Most notably, there has been much further testing, elaboration, and differentiation of the cognitive system of psychotherapy.

Other new advances include these: The classification of mood disorders has become more detailed. Genetic and cognitive neurobiological levels of analysis are being incorporated into the cognitive model, yielding a more complete analysis. The relation of manic symptoms to life events is better understood. Progress has occurred in identifying the genetic basis of the mood disorders, including schizoaffective disorder. “Neurotrophic” (keeping cells alive) and “neurogenesis” (stimulating growth of new cells) theories have been advanced, and are being tested. Studies in pharmacogenomics have identified genetic markers to predict individual drug response.

Greater knowledge on treatment is now available. Since the first edition appeared, several well-controlled studies have found that patients treated with cognitive therapy relapse less often than those treated with pharmacotherapy alone. Other investigations have shown substantial value in the routine use of maintenance treatment for depression, either drugs or cognitive behavior therapy.

The cognitive theory of depression and suicide has been subjected to empirical scrutiny, including tests of negative bias, hopelessness as a predictor of suicide, and content specificity. Randomized controlled trials have compared cognitive therapy to antidepressant medications. Results have shown that both the psychological and the somatic approaches are effective treatments of mood disorders, with some evidence supporting a combined approach. Greater therapist experience with cognitive therapy has been associated with better results, and cognitive therapy has been found to prevent suicide reattempts in adults. All these and other topics are included in the second edition of *Depression: Causes and Treatment*.

References


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**ABCT**

preregistration deadline: October 16

43rd Annual Convention

Nov. 19–22, 2009

New York City

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**Correspondence to Norah Vincent, Ph.D., University of Manitoba, P.O. Box 27, 771 Bannatyne Ave., Winnipeg, MB R3E 3N4 Canada; nvinston@exchange.hsc.mb.ca**
Special Interest Groups

Expanding the Scope of Clinical Psychology: The Neurocognitive Therapies/Translational Research SIG

Jan Mohlman, Rutgers University, and Thilo Deckersbach, Massachusetts General Hospital

The Neurocognitive Therapies/Translational Research Special Interest Group (NTTR SIG) is one of ABCT’s newest SIGs. We are a cadre of researchers and practitioners dedicated to the integration of traditional clinical psychology research with theory and methods of affective and cognitive neuroscience. The NTTR SIG seeks to bridge the gap between basic and applied science in understanding the nature and treatment of psychiatric disorders. Specifically, we seek to enhance the conceptualization of psychiatric disorders and the effectiveness of evidence-based interventions. Researchers and practitioners in this SIG apply brain imaging, neuropsychological and cognitive training, and related techniques as tools for increasing our understanding of anxiety, depression, addictions, schizophrenia, ADHD, and other psychological phenomena such as cognitive aging, medication response, and personality factors.

The NTTR SIG began in 2006 after a group of interested researchers noticed that although quickly gaining momentum in the larger field of clinical psychology, this particular perspective was underrepresented within ABCT, the premier professional organization for scientist practitioners. To date, we have over 50 members at both the professional and student levels, and hold annual events at the yearly conference of ABCT. The activities of the SIG include sponsored conference symposia from the neurocognitive perspective, guest speakers from in- and outside ABCT, workshops on neurocognitive methods, and a student poster exhibition and contest at the annual cocktail party. One does not need to have any expertise in these topics to become a member of NTTR; anyone with an interest in this multidisciplinary approach is encouraged to join.

In an effort to further the SIG’s mission to “bridge the gap between basic and applied science in understanding the nature and treatment of psychiatric disorders,” several SIG members developed and led a workshop at the November 2008 annual meeting. “Demystifying Brain and Body Measures for the Cognitive and Behavioral Therapist” was designed to provide basic information about three measures (fMRI, EEG/ERP, and heart rate variability) to individuals with little to no experience with this material. We hoped to share our enthusiasm for these measures with our ABCT colleagues and provide an opportunity for individuals to see how each measure can be applied to the study of emotion regulation. Small group discussions at the end of the workshop allowed workshop attendees to ask additional specific questions and receive consultation on research ideas. Feedback on the workshop was uniformly positive. Responders indicated that approximately 80% of the material was new to them, and a similar percentage reported that the presentation met their expectations. The enthusiasm was palpable in both the panel and the attendees: 100% of responders said that they were engaged in the material.

At this year’s ABCT conference, our featured speaker will be Dr. Mauricio Delgado from Rutgers University, who will present his innovative brain imaging research, “Regulating the Expectation of Positive or Negative Outcomes With Cognitive Strategies.” This work illustrates the differential activation of reward versus punishment pathways in the brain when subjects are making judgments about changing outcome contingencies in gambling-like tasks. Dr. Delgado conducts studies of fear conditioning and extinction, decision making, and social neuroscience, and is very interested in studying clinical patient groups. He will be available for brief consultation with SIG members after his talk.

Please take a moment to visit www.neurocognitive-therapies.com, where you can check out the NTTR SIG’s newsletters, poster contest winners, a roster of our members and their research labs, and information on how to join.

Correspondence to Jan Mohlman, Ph.D., Rutgers University, Dept. of Psychology, 152 Frelinghuysen Rd., Piscataway, NJ 08854 email: jmohlman@rci.rutgers.edu

ABCT’s Academic Training Committee is seeking sample course SYLLABI for posting on ABCT’s newly redesigned website.

We hope that such materials will continue to serve as a useful resource for members working on course design/enhancement. We welcome materials from courses at all levels (graduate and undergraduate) that incorporate ABCT values. These include, but are not limited to, courses on assessment and intervention, psychopathology, and research design. Please send materials to Jennifer Block Lerner, Ph.D. (lerner@lasalle.edu; 215-951-5179). If you have suggestions for other categories of training-related information that would be valuable to have on the website, please direct these to Kristi Salters-Pednault, Ph.D., at ksalters@bu.edu.
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his year marks the passing of one of the founders and giants in the field of behavior analysis and behavior therapy, Sidney W. Bijou, who succumbed to a fall on June 11, 2009, 7 months after his 100th birthday. From his earliest work in the military during World War II to his final university position at the University of Nevada, Reno, where he retired for the last time in December 2000 at the age of 92, Sid’s career was marked by his creativity, vigor, and persistence, and by the humility, humanity, and caring he brought to his work. His roles were many: clinician, professor, institute director, researcher, army captain, husband, father, colleague, as well as teacher, friend, and mentor to countless students of behavior analysis and behavior therapy.

Sid Bijou was born on November 12, 1908, in Arlington, MD. He received a degree in business administration from the University of Florida in 1933 and master’s and doctoral degrees from Columbia University in 1937 and the University of Iowa in 1941. His advisor at Iowa was Kenneth Spence, the well-known disciple of Clark Hull. Although Sid was interested in studying children’s behavior and problems, in order to work with Spence, he had to settle for research on experimental neurosis in rats. After serving in the Army during World War II, he returned to the Wayne County Training School in Michigan as a psychologist.

Psychology as a clinical discipline was just beginning in the late 1940s. B. F. Skinner had recently taken a position as Department Chair at Indiana University and Spence recommended Sid to Skinner as the right person to organize a clinical training program at IU. Sid took the position, but after 2 years Skinner went on to Harvard and Sid moved to the University of Washington in 1948 to direct the Institute for Child Development.

Dissatisfied with attempts to understand behavior using Hullian theory and treatment procedures based on play therapy, Bijou began to study the interaction between behavior and environmental variables. The pace of development quickened after a transformational sabbatical year at Harvard with Skinner, and in just a few years, he and colleagues such as Donald Baer, Montrose Wolf, Todd Risley, and Jay Birnbrauer, among others, developed new and effective instructional procedures and behavior therapies for normal, retarded, and autistic children. His team did groundbreaking work on programmed instruction, classroom management procedures such as time-out, and on the importance of attention in regulating children’s behavior. The first systematic application of behavioral principles to autistic children occurred under his supervision.

During this extremely creative period Bijou published a number of seminal papers and established the University of Washington as a leading center for operant research. This work formed the foundation for the penetration of behavioral principles into applied psychology. It helped create the fields of applied behavior analysis and child behavior therapy, and demonstrated the key role of contingencies of reinforcement in the development and maintenance of behavioral patterns of clinical and educational importance.

In 1965, Bijou took a professorship at the University of Illinois and continued his research and teaching, advancing work in parent training, early childhood development, field research, and education. After 10 years at Illinois, Bijou retired and took a position as adjunct professor of psychology and special education at the University of Arizona.

In his career, Sid helped found and served as the first editor of the Journal of Experimental Child Psychology and was president of the American Psychological Association’s Division 7 for Developmental Psychology. He co-authored several important books, including two highly influential volumes on child development with Donald Baer.

Although Sid “retired” in 1975, it would be another 25 years before that word could fairly be applied to his lifestyle and work habits. He continued to conduct research and work with graduate students and colleagues. While at Arizona, for example, he published over 50 papers. In part to be closer to their two children living on the West Coast, Sid and his wife, Janet, left Arizona in 1993 and moved to Nevada where Sid was appointed Distinguished Professor Emeritus in the Department of Psychology at the University of Nevada, Reno. At Nevada, he helped build a new doctoral program in behavior analysis, and he co-founded (with Pat Ghezzi) a program for the behavioral treatment of autism. Sid and Janet endowed a fellowship fund at UNR for graduate students interested in child development from a behavioral perspective, and a similar fellowship awarded by the Association for Behavior Analysis. Even into his 90’s he continued to consult and work with graduate students.

Bijou received many awards. Among them was the G. Stanley Hall Award in Child Development from the American Psychological Association, the Edgar A. Doll Award in Mental Retardation, the Don Hake Award in Basic and Applied Behavioral Research, and the Distinguished Science Award from the National Association of Retarded Citizens. As a result of his work in promoting behavioral science in Mexico and Latin America, the University of Veracruz in Mexico awarded him an honorary doctoral degree in 2001.

What cannot be captured by this list of achievements was his amazing combination of intellect and commitment on the one hand, and humility and compassion on the other. As well known as Sid was, he would be even more so if he had not constantly pushed students and junior colleagues into the limelight instead of taking it for himself. He spent long hours consulting about cases or research projects without any expectation of credit. He was slow to anger, quick to see the good in others, and loving and gentle in his interactions with all. Even in his last years, he retained his humor and his interest in the good science can do. He was a kind and good man, who lived a life that left us all better for it.
Recently, mindfulness-based interventions have garnered increasing interest in the therapeutic community. Mindfulness-based interventions, such as Mindfulness-Based Stress Reduction (Kabat-Zinn, 1982), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), and Dialectical Behavior Therapy (Linehan, 1993), have been linked to improvements in a wide range of psychological symptoms. In Mindfulness and the Therapeutic Relationship, the authors suggest that benefits of mindfulness do not lie in the interventions themselves, but in the way a therapist’s own mindfulness practice can enhance the therapeutic alliance with clients. Mindfulness training cultivates nonjudgmental, present-moment awareness. The authors of this book contend that these qualities are essential in the formation of a strong therapeutic relationship.

Mindfulness and the Therapeutic Relationship is divided into four sections. The first section begins with background information on mindfulness, specifically operational definitions and measurement tools. The authors then emphasize the importance of a strong therapeutic alliance for positive client outcomes. They cite empirical evidence that therapist-client relationship factors (understanding, genuineness, warmth, and positive regard) predict client outcomes better than the specific clinical techniques employed. This research has been conducted on other forms of psychotherapy (psychodynamic, behavioral, cognitive-behavioral, gestalt, and person-centered therapy) with little attention to mindfulness-based interventions. The authors argue, however, that research on mindfulness interventions will ultimately follow the trajectory of other psychotherapies, attributing greater influence on client outcomes to relationship factors. Finally, mindfulness is described as both a technique and as a way of facilitating therapeutic presence. The authors suggest that a therapist’s mindfulness practice can enhance the therapeutic relationship.

The second section details specific qualities of the therapeutic alliance that can be enhanced through mindfulness training. Parallels are drawn between Carl Rogers’ (1957) necessary and sufficient conditions of change and qualities of mindfulness. Specifically, congruence (therapist is aware of his or her own experience during the session), unconditional positive regard, and empathic understanding correspond highly with mindful teachings of nonjudgmental, present-moment awareness. The authors of the chapters in this section describe the difficulty in teaching beginning therapists these skills and suggest that mindfulness training may be a way to cultivate them. Detailed descriptions of Buddhist principles, their relationship to mindfulness, and implications for the therapeutic alliance are provided. For example, the authors explore how the Buddhist principle of the four immeasurable minds (love, compassion, joy, and equanimity) can serve as a way for therapist to understand a truly therapeutic presence.

The third section of this book describes how enhancing a therapist’s level of mindfulness may improve the administration of several types of psychological interventions, including behavioral, psychodynamic, and family systems therapies. The authors outline how therapist mindfulness training may advance the therapeutic alliance in general. They also note that some qualities cultivated by mindfulness (e.g., awareness, nonjudgment, nonreactivity to internal experience) may be particularly suited to developing a strong therapeutic relationship in specific treatment modalities. For example, the importance of an open and accepting therapist is highlighted in mindfulness-based relapse prevention (contrasting a more judgmental “tough-love” approach to addictive behavior), whereas mindful attention and awareness may facilitate psychodynamic therapy by increasing therapists’ ability to metacommunicate with clients to help prevent further relationship problems.

Finally, the fourth section of this book provides strategies for integrating mindfulness into therapeutic listening and clinical training. Empirical evidence suggesting that mindfulness practice cultivates empathy is presented as support for including mindfulness practice in clinical training programs. Descriptions of several forms of mindfulness meditation are presented, as well as sample practice logs. Additionally, specific mindfulness practices for enhancing relationships and listening skills are also provided.

Overall, Mindfulness and the Therapeutic Relationship represents an important addition to the literature on including mindfulness principles in Western psychological practice. Mindfulness practice is typically described as a therapeutic intervention; however, the authors provide compelling theoretical rationale and preliminary evidence to suggest that a therapist’s own mindfulness practice may enhance his or her ability to form positive therapeutic alliances. Clinicians and educators of future clinicians will likely benefit from the practical strategies (meditation exercises, practice logs, etc.) provided.

The authors strongly support the notion that positive client outcomes are mainly determined by a strong therapeutic alliance. They indicate that the role of mindfulness in the therapy room should lie in the development of a positive working relationship facilitated by the therapist’s own mindfulness practice. They may, however, be too quick to dismiss the direct effect that a client’s mindfulness practice has on positive outcomes. Although the authors cite evidence suggesting that other forms of psychotherapy do not account for as much variance in client outcomes as relationship factors, the leap to include mindfulness-based interventions with these findings (without evidence) may be off-putting to some readers. Additionally, they do not cite evidence for the opposing position. Many researchers believe that for certain mental disorders there are psychotherapies that exert their effects through theory-driven, specific means (Chambless & Ollendick, 2001; DeRubeis, Bortman, & Gibbons, 2005). Exposure and response prevention for obsessive-compulsive disorder, cognitive therapy for panic disorder, exposure therapy for posttraumatic stress disorder, and cognitive-behavioral group therapy for social phobia are considered efficacious and specific disorders/treatment pairs (DeRubeis & Crits-Christoph, 1998). Ultimately, the message that mindfulness practice may positively influence a clinician’s ability to provide successful therapy is impossible to overlook.
References


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**Call for Students**

**Serve as an International Colleague**

ABCT is excited to announce the launch of a new networking opportunity for students: The International Student Colleague Program!

**What is the program?**

The International Student Colleague Program pairs students from different countries with students from the United States or Canada. Pairing is based on research interests and language match.

This is a great opportunity for networking with students from different parts of the world who share similar professional interests, plus the ability to introduce your student colleague to your colleagues, friends and ABCT leaders, and show them the best that ABCT has to offer!

**What are the requirements?**

Host students need to have attended an ABCT convention in the past and be familiar with the Association such as knowing about Special Interest Groups (SIGs), the Friday night SIG Expo & Welcoming Cocktail Party, the program book, and willing to spend some time with the student colleague during the convention.

To participate, students will be required to complete a short application so that the best possible match is made. The application will be made available on the ABCT website.

**What time commitment is involved?**

Once you are paired with a student, you will be sent information about contacting your international student colleague to answer any questions about ABCT or the convention. You are encouraged to establish correspondence via email or phone. You are also asked to meet with your student colleague at the convention and introduce them to other ABCT members.

More information will be made available on the ABCT website and the list-serve

**Whom do I contact if I have questions?**

Please contact T. Lindsey Burrell at tlindsey.burrell@ttu.edu or Joaquin Borrego at Joaquin.Borrego@ttu.edu for more information! Use the subject heading: ABCT International Student Colleague Program.
The Find-a-Therapist Survey

Gerald Tarlow, Chair, Clinical Directory and Referral Committee

The Find-a-Therapist (FAT) link on the ABCT website was developed in order to help ABCT members promote their practice and to help members and consumers find appropriate therapist referrals. One of the goals of the Clinical Directory and Referral Committee is to help achieve these goals. Up until 1998, members had to use a printed membership directory if they wanted to find an appropriate referral, or an ABCT staff member would mail a printout of a state listing to a consumer’s request for referrals. In 1999, ABCT published its first on-line therapist directory. Since that time, ABCT has strived to continually improve the usefulness and quality of the directory.

Many members are not aware of the differences between the membership directory, the FAT directory, and the expanded FAT listing. All ABCT members are listed in the membership directory, even if they do not have a clinical practice. This directory is available online to all ABCT members via their log-in and password, but not to the public. Any member can choose to be listed in the FAT directory. The FAT directory is available online to members and the public. In order to have an expanded listing in FAT members must pay an additional $50 per year. This expanded FAT includes a brief description of the practitioner’s expertise, practice philosophy, and a link to their website.

Recently ABCT conducted a survey of its members in an effort to determine how the FAT link on the ABCT website is being used and what improvements can be made. The purpose of this article is to briefly summarize the results of the survey and to make some recommendations for further consideration.

Seventy-five members completed the survey. Approximately 80% had previously used the FAT link on the website and 20% had never used the link. Of the people that did not use the FAT link, the majority used friends or colleagues to find referrals (50%) or they did not need to obtain referral information from within ABCT. A small percentage of responders (19%) did not know about the FAT directory and 12.5% used the listserve to get referrals.

The overall experience that people had using the FAT directory was very positive. Members felt that the FAT link was “user-friendly,” helped them obtain referral information, and provided comprehensive search criteria. Most members reported that they were very likely to use the FAT directory in the future.

Seventy-two percent of the responders were listed in the FAT directory, but only 33% had ever received a referral through the FAT directory. Of the people that received referrals, most people have only had 1 or 2 referrals per year. Sixty percent of the responders have told patients to use the FAT directory and 70% used the FAT directory to find out information about colleagues. When people did use the FAT directory to find information about colleagues, 90% rated the FAT as “useful.”

Sixty-eight percent of responders have updated their FAT listing, but only 24% have updated their practice particulars in the expanded FAT directory. Sixty-four percent plan on renewing their expanded FAT listing.

What We Learned

The results of the survey indicate that the FAT directory is being used by many members and is very useful. It is important to remember to update your FAT listing. Many members would like to see an easier way to search for a therapist in a particular geographic location. Although it is possible to search for a therapist in a particular county, many members do not find this very useful (77%). The most common suggestion is to be able to search around a certain mile radius of a particular zip code or city. The Clinical Directory and Referral Committee has been looking into this possibility and the cost of being able to conduct this type of search. We are also looking at the feasibility of adding practitioners’ photographs to their listing. We would like to find more ways to increase the referrals to our members and therefore increase the percentage of members renewing their expanded FAT listing.

The FAT directory continues to be a work in progress. There are many other websites that provide referrals (e.g., APA, Psychology Today, and ADAA). We would like the FAT directory to be the first place consumers search for a CBT therapist. We would like the FAT directory to also be the easiest method for our members to find a referral. The committee welcomes any suggestions for improving this important member service.

Where We Are Going

In an effort to introduce the public to the benefits of the behavioral therapies in a more personal way, we launched a new program last year, the Featured Clinician of the Month. Each month we recognize an ABCT member with an interview and photograph on our home page. Soon we will be adding the ABCT Self-Help Book Seal of Merit to help the public find books that explain empirically supported treatments.

The Find a Therapist is the most frequently visited page on our website throughout the year, averaging over 8,700 hits per month. When ABCT transitioned to a new database and the FAT page was temporarily down, ABCT staff handled 75 to 100 calls or emails daily from the public requesting referral information, a good indication that the general public is aware of this terrific service (happily the service is now up and running once again). If you see clients, I strongly recommend that you keep your information current if already participating, or sign up today if you see clients and aren’t taking advantage of this membership benefit.

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**glossary of terms**

**Membership Directory:** A directory of all ABCT members, available online to all ABCT members (not available to the public).

**Find-a-Therapist Directory:** A directory of licensed full and new professional ABCT members who take referrals. This is accessible to the CBT-seeking public from our home page.

**Expanded Find-a-Therapist Directory:** For an additional $50/year, your practice philosophy, special services, and link to your website will be included in your FAT listing.
New York City Has Something for Everyone

Jan Mohlman, Chair, Local Arrangements Committee

A BCT’s 2009 Local Arrangements Committee looks forward to seeing you at Times Square’s Marriott Marquis Hotel this November! New York is (arguably) the world’s most exciting city, where residents and visitors alike can realize their long-held dreams and fantasies.

The city’s array of sights and events, architecture, culture, performance, cuisine, and its beautiful historic character make it a fascinating place to live and to visit. Although New York City can be expensive, it is easy to have a thrilling, fun-filled day in NYC for free. If you are on a budget, the Local Arrangements Committee recommends that you seek out “free things to do in NYC” (try a Google search), or go to http://nymag.com/visitorsguide/ for a guide to free events and attractions, cheap eats, and budget itineraries. As with every thriving metropolis, popular events can attract a crowd. The more you can reserve or plan in advance, the better. Events that definitely require advance planning include (a) attending specific Broadway shows (but visit the TKTS website, www.tdf.org/tkts, if you’re not set on any one show), (b) getting great seats for any type of show (music, theater, etc.), (c) dining at any popular restaurant, or (d) visiting special ticketed museum exhibits. Those who try to do things “on the fly” will have a much harder time fitting these activities in between conference events. We recommend utilizing Time Out New York online (http://newyork.timeout.com), a wonderful resource for planning your trip’s activities. We have found their reviews of restaurants, exhibits, and attractions to be helpful and accurate.

Visit the Local Arrangements Table!

If you need any kind of assistance, be sure to stop by the Local Arrangements table at the conference. We’ll have many helpful tips and aids to help you get the most out of your New York trip, including free subway maps, professional restaurant guides and eating suggestions from two local chefs, and our own handouts with instructions for taking themed, self-guided, 1-hour walking tours (e.g., LGBT history, NY Music, East Village or West Village Eating Tour, Sex and the City, Romance for Couples). Here we provide some advance information to help you get the most out of your trip to this year’s conference.

Venue

The Marriott Marquis Hotel is conveniently located in Times Square, in the heart of the theater district and restaurant row. The hotel is accessible by almost any mode of transportation, including subway (Times Square/42nd St. stop), taxi, or even hansom carriage and pedi-cab! Peruse the Marriott Marquis’ website and select the link ABOUT THIS HOTEL for more about hotel amenities. The Marriott’s website also provides descriptions of several of Manhattan’s neighborhoods, such as Greenwich Village, Soho, Tribeca, and Harlem. We encourage you to make use of the concierge service at the hotel at any point during your trip—the concierge is well informed about how to navigate the city and gain best access to NYC events.

Weather

Mid-November can be a transitional phase in terms of weather, but evenings are sure to be chilly. We recommend that you bring a coat, hat, and gloves, and follow the time-honored New York tradition of dressing in layers. And bring all your black clothing if you want to blend in with the locals!

Getting Here: Airports

For those traveling by air, NYC is served by LaGuardia Airport and John F. Kennedy International Airport, both in Queens, and Newark Liberty International Airport in neighboring New Jersey. LaGuardia airport primarily serves domestic destinations, with a small number of flights to and from selected Canadian and Caribbean destinations. Kennedy and Newark airports each serve both domestic and international destinations. All three airports provide access to the city via taxis, buses, subways, and trains.

John F. Kennedy International Airport (JFK)
Jamaica, Queens, NY 11430
718-244-4444

This airport is New York’s largest, serving more than 75 primarily international airlines. It is approximately 15 miles from midtown Manhattan. Getting to midtown Manhattan from JFK:
TAXI: $45 flat fee (non-metered) plus bridge and tunnel tolls and gratuity; 30 to 60 minutes to midtown Manhattan.
212-NYC-TAXI
AIRTRAIN JFK: $5 (children under 5 free); 60 to 90 minutes to Midtown and upper Manhattan. Around the airport, AirTrain is free.

LaGuardia Airport (LGA)
Jackson Heights, Queens, NY 11371
718-533-3400

This is New York’s second-largest airport, with more than 20 airlines serving mostly domestic destinations, Canada, and the Caribbean from five passenger terminals. It is on the northern shore of Queens, directly across the East River, about 9 miles from midtown Manhattan.
TAXI: Metered fare; $16 to $26 plus bridge and tunnel tolls and gratuity.

Newark Liberty International Airport (EWR)
Located in New Jersey, Newark Airport is 16 miles from midtown Manhattan. Over 30 million passengers pass through Newark Airport annually.
TAXI: Metered fare; approximately $60 (plus tolls) to the Marriott.

Private car services are also available and preclude the need to wait in the airport queue for a cab. The two most popular are Carmel, (212) 666-6666, and Dial 7 (212) 777-7777. Prices are variable but you can save by booking your private car online, in advance of your trip.

The Marriott does not offer complimentary shuttle service, but there are several affordable vans from all airports, including SuperShuttle and Go Airlink. You can also take an express New York Airport Service bus from any of the airports to the Port Authority Bus Terminal at 43rd Street and 8th Avenue, which is just a few blocks from the Marriott Marquis. The express bus is recommended by the Local Arrangements Committee for those on a budget because it is inexpensive and relatively fast. You should check in at the ground transporta-
tion desk at any of the airports to make use of these options.

You can also take the A train (making local subway stops) from JFK to Times Square, or New Jersey Transit train service from EWR to Penn Station at 33rd Street and 8th Avenue, which takes approximately 20 to 30 minutes.

If you are driving to the conference in your own private automobile, please be sure to confirm parking arrangements well ahead of time, and do not leave your parked car unattended for any length of time in the hotel vicinity, for risk of being ticketed or towed.

Getting Here: Train Stations

There are two train stations in New York City: Penn Station and Grand Central Station. Penn Station, located at 33rd St. and 8th Avenue, houses Amtrak, the Long Island Railroad, and New Jersey Transit rail service. Grand Central Station on 44th St. and Park Avenue serves Metropolitan and Connecticut trains, and is utilized primarily by local commuters.

We recommend a visit to Grand Central even if you are not commuting — it beats Penn Station for ambiance hands down, as it is home to the famous Oyster Bar Restaurant, Michael Jordan’s Steakhouse, and the trendy Campbell Apartment Bar. The NYC Transit Museum is also located at Grand Central and is worth a visit, as are several other unique shops (Pylones Gift Shop) and restaurants in the food court (Two Boots Pizza).

Getting Around: Subways

Once you’re here, take a ride on the NYC subway, which locals consider to be the eighth wonder of the world. Everything you have ever wanted to know about using the subway can be found at www.mta.info/nyct/subway/index.html. To use the subway you will need to purchase a MetroCard from one of the vending machines located in any subway station. The machines accept cash, debit, or credit cards, and the subway fare is expected to be $2.50 per ride by November 2009. Stop by the Local Arrangements table for help navigating the subway system or to pick up a free souvenir subway map. They make great wall art for your home or office!

Morning Fun Run

The NYC Marathon takes place in early November, thus the city is likely to be in its “runners’ aftermath” phase during the ABCT conference. To embark on your own fun run, simply walk west from the Marriott over to the Hudson River Greenway, an idyllic bike and pedestrian path that extends all the way around the island of Manhattan. You can run uptown past the U.S.S. Intrepid, or downtown toward NY Harbor; either direction offers interesting sights and great people-watching opportunities. Those runners who are more serious can also join events organized by the New York Road Runners Club, http://www.nyrr.org.

Other Sports

Athletic types may also wish to stop by the Chelsea Piers Sports Complex, a truly astounding facility at 23rd Street at the Hudson River. You can golf, bowl, ice skate, play tennis, or pamper yourself at the spa! Visit http://www.chelseapiers.com.

Cuisine

There are too many excellent places to eat in New York City to list here; however, we recommend that you sample some of the city’s fantastic ethnic cuisine for at least one of your NY meals. Try Indian food on East 6th Street between 1st and 2nd Avenues; Thai food on 9th Avenue between 38th and 55th Streets; Korean food in Little Korea (31st–33rd Street between 5th and 6th Avenues); Italian food in Little Italy (Mott, Elizabeth, and Mulberry Streets between Houston and Canal Streets); or Chinese food in Chinatown (bordered on the north by Canal Street, the west by Centre Street, the south by Worth Street, and the east by Bowery). Or “go American” at any of New York’s excellent steakhouses (Peter Luger, Smith & Wollensky, Sparks) or barbecue joints (Dinosaur Bar-B-Q, Virgil’s, Rub BBQ).

And no trip to the Big Apple would be complete without a slice of thin crust pizza, a hot dog from Papaya King or any sidewalk cart, an authentic egg cream (a delightfully refreshing beverage that contains neither eggs nor cream) from Gem Spa Newsstand, freshly baked bagels from H & H or elaborately decorated cupcakes from Cupcake Café (the latter two of which are located a couple of blocks west of the hotel on Ninth Avenue).

Touring the City

Those with limited time in New York might consider the popular Circle Line or Spirit of New York boat cruises (www.circle-line42.com; www.spiritofnewyork.com). Or purchase a pass for any of the double-decker tour buses for all day “jump-on, jump-off” privileges (/www.nyours.us/tours). Either of these are great fun and perhaps the easiest ways to see the city in its entirety. We are particularly fond of the evening boat rides around NY Harbor. In relatively good weather, it is also great fun to visit the observation decks at the top of the Empire State Building or Rockefeller Center (Top o’ the Rock). The hotel concierge can direct you to any of these activities.

Shopping for Clothing

The mother of all department stores, Macy’s Herald Square, is within walking distance of the Marriott at 34th Street and 7th Avenue; her chic sister, Bloomingdales, is at 59th Street and Lexington Avenue (even more high-end boutiques and stores can be found along Fifth Avenue, Madison Avenue, and in Soho). However, many very, very chic locals prefer to shop at Century 21, a discount designer department store across the street from the former site of the World Trade Center (www.c21stores.com). We also recommend going off the beaten path to smaller boutiques in the Nolita area such as The Market NYC, a weekly flea-market housed in a church gymnasium that features clothing, bags, and housewares by up-and-coming local designers (www.themarketnyc.com).

Uniquely New York

Many people do not think of farming when they think of NYC; however, the Union Square Greenmarket (Broadway at 17th St. and vicinity) is an amazing farmers’ market, known the world over for artisanal cheeses and meats, superior produce, interesting housewares, and boutique wines from Long Island, rural New Jersey, Upstate NY, and other nearby areas. Pick up snacks for your hotel room or find unique items to take home, such as molded beeswax candles and handmade hairbrushes. The Union Square Greenmarket is open on Monday, Wednesday, Friday, and Saturday from 8 A.M. until 6 P.M.

Visiting Museums

New York is home to many of the world’s greatest museums, galleries, and cultural centers, and one could easily spend an entire day at any of the major museums (e.g., Museum of Natural History, Metropolitan Museum of Art, Museum of Modern Art). To avoid crowds, visit museums as early as possible, preferably right at the time they open. Many museums have free admission or suggested admission (pay...
what you wish). If you are a member of any museum in another city, bring your membership card with you because many NY venues offer reciprocal privileges. Among the pay-what-you-wish are the Met (Metropolitan Museum of Art), Whitney Museum of American Art, Jewish Museum, and Cooper-Hewitt National Design Museum. Brooklyn Museum of Art is free the first Saturday of each month. National Museum of the American Indian and Hispanic Society of American are free all the time. For a list of NYC’s lesser-known but excellent museums and galleries, stop by the Local Arrangements table.

Bar Hopping

The two most popular bar hopping areas in NYC for the younger set are probably the East Village and Lower East Side. Both feature a wide range of watering holes, most with affordable prices, and lots of interesting people. Or, try the famous bar atop the Marriott Marquis, The View, which slowly rotates in a complete circle every hour! You’ll have a panoramic 360-degree view of Manhattan and all surrounding areas. It is spectacular and worth a visit.

Discount Tickets to Broadway Shows

TKTS Discount Booths offer tickets to Broadway and Off-Broadway musicals and plays at up to 50% off, with dozens of productions on sale every day. The NY Theater Development Fund operates a TKTS discount booth in Times Square (W. 46th St., tdf.org), selling day-of-performance tickets only.

To obtain discount tickets, line up in the TKTS queue and hope that tickets to your favorite show are still available once you reach the front of the line. It is beneficial to have several shows in mind, as the more popular shows sell out relatively quickly. TKTS Times Square accepts credit cards, cash, traveler’s checks, or TKTS gift certificates. For more information, visit http://www.tkts.com.

More That’s Free and Fun!

Take a free tour of the historic Grand Central Terminal Wednesdays and Fridays at 12:30 PM. See the Today Show being taped at Rockefeller Center (the corner of 49th Street between 5th and 6th Avenues) any morning from 7:00 to 11:00 A.M. Or visit Central Park, the Staten Island Ferry, Sony’s Wonder Technology Lab, St. Patrick’s Cathedral, FAO Schwarz toy store, Tiffany & Co., or the New York Stock Exchange . . . they’re all free!

To take fun and informative video tours of NYC in advance of your trip, we recommend visiting Little Bytes of the Big Apple at feed://littlebytes.blip.tv/rss.

And: Visit ABCT’s website for the central office staff NYC picks and recommendations.

We can’t wait to see you in November!

LOCAL ARRANGEMENTS COMMITTEE:
Jan Nohrman (Chair), Rebecca Price, Alison Staples, and Dorian Hunter-Reel

Visit ABCT online from now until November 19–22 for crucial facts and discoveries about the Annual Convention in NYC, including:

• Registration
• Hotel
• Highlights / Invited speakers
• Intensive learning sessions
• Itinerary Planner
• SIG meetings and networking
• Poster guidelines
• Student volunteering opportunities

... and much much more
We urge you to register by the deadline of November 2, 2009. After this date, you can register only in New York City (at the meeting site) from November 19–22. Preregister on-line at www.abct.org to ensure that you get into your desired sessions! To design your optimal convention experience, check out the Itinerary Planner at www.abct.org/conv2009.

What Does the General Registration Fee Cover?
General registration gives you access to all of the Symposia, Clinical Round Tables, Posters, Panel Discussions, Special Sessions, Invited Addresses, and SIG meetings that you can possibly attend Friday through Sunday. Ticketed sessions—Workshops, Master Clinician Seminars, and AMASS—are not covered under the general registration fee.

What Are “Preconvention Activities”?
Full- or half-day intensive learning experiences—Institutes and Clinical Intervention Trainings—that take place on Wednesday and Thursday, November 18 and 19.

How Do I Preregister?
To receive discounted preregistration rates, please register BEFORE the October 16 deadline.

On-line: The quickest method is to register on-line at www.abct.org. Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members’ discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to (a) renew and then (b) register for the meeting. To get member rates at this conference, your ABCT dues must be paid through 2010. (The ABCT member year is November 1–October 31.) You can also renew at the convention site in New York prior to registering.

Fax: You may also fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will likely cause double payment. Faxed registrations received from Oct. 19 through Oct. 31 will be accepted at the on-site rates. No registrations will be accepted in any format from November 1 until November 15.

Mail: All preregistrations that are paid by check (made out to ABCT) must be mailed to ABCT. For preregistration rates, forms must be postmarked by the deadline date: October 16. Forms postmarked from October 19 through October 31 will be processed at the on-site rates. Forms postmarked after October 31 will be returned. There will be no exceptions.

Do Presenters Have to Pay?
All presenters (except for the first two Workshop and Master Clinician Seminar presenters) must pay to register.

Confirmation?
ABCT sends e-mail confirmation shortly after you register on-line. Hard copy confirmation letters are also sent. If you have registered and do not receive a letter by November 1, please email Tonya Childers at tchilders@abct.org.

Must I Pay the General Registration Fee If I’m Only Attending Ticketed Sessions?
No.

What Is Your Refund Policy?
Refund requests must be in writing and sent to tchilders@abct.org. Refunds will be made only until the October 16 deadline, and a $40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 17.

What Are the On-Site Registration Hours?
- Thursday
  Preregistration pick-up: 11:00 a.m.–8:00 p.m.
  On-site registration: 3:00 p.m.–8:00 p.m.
  Clinical Intervention Trainings: 7:30–8:30 a.m
  1-Day Institute: 7:30–8:30 a.m
  Half-day Institute: 11:00 a.m.
  AMASS: 11:00 a.m.
- Friday: 7:30 a.m.–3:00 p.m.
- Saturday: 8:00 a.m.–3:00 p.m.
- Sunday: 8:00 a.m.–11:30 a.m.
Clinical Grand Rounds

NEW YORK CITY

Clinical Grand Rounds 1
Cognitive Restructuring Versus Cognitive Defusion | Judith Beck & Steven Hayes
Friday, Nov. 20, Manhattan Ballroom, 9:30-11:00 a.m.

Clinical Grand Rounds 2
Body Dysmorphic Disorder: What You See Is Not What I See | Fugen Neziroglu
Friday, Nov. 20, Manhattan Ballroom, 11:30-1:00 p.m.

Clinical Grand Rounds 3
Cognitive-Behavioral Strategies in Family Therapy | Frank Dattilio
Friday, Nov. 20, Manhattan Ballroom, 2:00-3:30 p.m.

Register today! www.abct.org